U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 December 2004

CASE No. 2003-BLA-6138

In the Matter of

EMMIT H. HUTTON,
Claimant,

v.

ITMAN COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

S. F. Raymond Smith, Esquire
For the Claimant

Ashley Harman, Esquire
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claimant's subsequent claim after a denial of his prior claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the Act). DX 1. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, and 727 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis or CWP) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.

PROCEDURAL HISTORY

Claimant filed his first claim for benefits with the Department of Labor (DOL) on March 25, 1996; that claim was denied on June 19, 1996, by a DOL claims examiner. DX 1. Claimant took no further action until he filed the current claim on March 20, 2002. DX 3. Because it was filed more than one year after the prior denial, it is a subsequent claim governed by § 725.309. The District Director issued a Proposed Decision and Order on April 10, 2003, in which he denied the claim for failure to establish the existence of pneumoconiosis and a totally disabling respiratory impairment. DX 29. On April 16, 2003, Claimant objected to the findings of the District Director and requested a formal hearing before an ALJ. DX 30.

On April 27, 2004, I held a hearing in Beckley, West Virginia. The Claimant and Employer, both represented by counsel, were afforded the full opportunity to present evidence and argument. I admitted Director's exhibits 1–36 and Claimant's exhibits 1–2. TR 5–6. Pursuant to my Order Granting Employer's Motion for Reconsideration and Revising Previous Order Regarding Admission of Evidence, dated July 13, 2004, I admitted portions of Employer's exhibits 1, 2, 5, 6, 7, and 8. My discussion and conclusions regarding the admissibility of Employer's evidence is hereby incorporated by reference into this Decision and Order

The parties stipulated to Employer's proper designation as the Responsible Operator, to fifteen years of qualifying coal-mine employment by the Claimant, and to the qualification of one dependent, Claimant's wife Linda, for purposes of augmentation of benefits. TR 7–8.

ISSUES

(1) Whether the evidence establishes a change in a condition of entitlement pursuant to 20 C.F.R. § 725.309(d), and if so:
(2) Whether the miner has pneumoconiosis;
(3) Whether the miner's pneumoconiosis arose out of his coal mine employment;
(4) Whether the miner is totally disabled; and
(5) Whether the miner's disability is due to pneumoconiosis.

FINDINGS OF FACT

Length of Coal Mine Employment

The parties agree and I find that the evidence of record establishes that Claimant was a coal miner within the meaning of the Act and Regulations for fifteen years. TR 7.

Date of Filing

Claimant filed his current claim on March 20, 2002, more than one year after a claims examiner denied his previous claim on June 19, 1996. DX 3. I find that Claimant timely filed the present claim pursuant to 20 C.F.R § 725.309.

Responsible Operator

The parties agree and I find that Itman Coal Company is the last employer for whom the Claimant worked a cumulative period of at least one year. Therefore, Employer is the properly designated responsible coal mine operator in this case.

Dependents

I find that Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Linda Mae Houston Hutton. DX 7; TR 7–8.

Claimant's Testimony

The Claimant was born on September 3, 1945. DX 3; TR 8. He testified that he worked as a coal miner for fifteen years. His very last job, which lasted one week, was as a face man at the mine. However, the last job he held for at least a year was that of belt man. TR 9. It was underground work that required him to use a shovel that was fourteen inches across. He worked in twenty-eight- to thirty-inch seams. Mr. Hutton began coal mining in August 1971 and testified that all of his coal mine employment was underground. TR 10.

Mr. Hutton testified that he quit smoking six years ago with his first heart attack. TR 12. He continued to smoke off and on, without any regularity, until December 2003, when he quit altogether. He did not testify as to the length of time he smoked or the extent of his habit.

Medical Evidence

Chest X-rays

Exh.#	**X-ray Date**	**Physician/Qualifications**	**Interpretation**
DX 1	5/3/96	Ranavaya	1/0; s/t; 4 zones
DX 1	5/3/96	Gaziano/B	Negative
DX 1	5/3/96	Francke/BCR, B	Negative
DX 13	6/5/02	Patel/BCR, B	1/0; p/s; 6 zones; surgical clip in left lung zone; plate atelectasis or scarring in right lung zones
DX 14	6/5/02	Binns/BCR, B	Quality 2; metallic foreign body or artifact in left chest wall
DX 15	6/5/02	Wiot/BCR, B	Negative; emphysema; metallic density superimposed over left lower lung field, probably either an artifact or a foreign body
EX 2	10/14/02	Meyer/BCR, B	Negative; post-surgical changes at lung bases

EX 2	1/8/03	Spitz/BCR, B	Negative; metallic clip overlying left lower lung; linear strand right lower lung
CX 1	3/5/04	Miller/B	1/1; p/q; 6 zones
CX 2	3/5/04	Pathak/BCR, B	1/2; p/q; 6 zones; emphysema
EX 5	3/5/04	Wiot/BCR, B	Negative; metallic density superimposed over left lower lung field

Pulmonary Function Studies[1]

Exh.#	Date	Age/Height	FEV1	MVV	FVC	Qualify?	Impression
DX 1	5/3/96	50/76"	3.10 3.36*	127 130*	4.73 5.05*	No No	
DX 12	6/4/02	56/78"	3.11 2.85*	103	5.45 5.10*	No No	
DX 16	10/14/02	57/76"	2.84 3.24*	99	4.60 5.18*	No No	
DX 17	1/8/03	57/76"	3.02 3.07*		4.83 5.49*	No No	Mild irreversible obstruction; normal lung volumes; moderate diffusion impairment

Arterial Blood Gas Studies

Exh.#	Date	pCO2	pO2	Qualify?	Impression
DX 1	5/3/96	37.2	80.5	No	
DX 10	6/4/02	34.6	59.6	Yes	Found technically acceptable by Dr. Gaziano (Board-certified in internal medicine and chest disease). DX 11.
DX 16	10/14/02	37	71	No	
DX 17	1/8/03	36	67	No	

Physicians' Reports

On May 3, 1996, in conjunction with Claimant's initial claim, Mohammed I. Ranavaya, M.D., examined Mr. Hutton. DX 1. He considered a sixteen-year history of coal mine employment, lastly as a faceman. He also took into account a smoking history of one pack of cigarettes a day for twenty years before quitting in 1996. Mr. Hutton complained of sputum production, wheezing, shortness of breath, a cough, chest pain, orthopnea, and ankle edema. He

[1] An asterisk (*) indicates a post-bronchodilator value.

provided a medical history significant for wheezing, arthritis, heart disease, high blood pressure, and a left lung tumor.

Dr. Ranavaya conducted an x-ray, a pulmonary function study, a blood gas study, and an EKG. Physical examination showed scattered wheezes. Dr. Ranavaya diagnosed pneumoconiosis based on sixteen years of coal dust exposure and the x-ray evidence. He further diagnosed hypertension. In Dr. Ranavaya's opinion, the Claimant had a mild impairment according to the pulmonary function study administered; the physician opined that pneumoconiosis played a major role in the cause of that disability.

On June 4, 2002, Charles E. Porterfield, D.O., examined the Claimant. DX 9. Dr. Porterfield noted that Mr. Hutton had worked fifteen years in the coal mines, lastly as a foreman. Dr. Hutton conducted an x-ray, a blood gas study, and a pulmonary function study. The x-ray was read as category 1/0 pneumoconiosis. The pulmonary function study was interpreted as showing a class 2 impairment, leaving Claimant 25% disabled, and the arterial blood gas study was interpreted as revealing total disability. Dr. Hutton also considered a medical history of heart disease and surgery, hypertension, hypothyroidism, and a back injury. He was given a history of smoking from 1962 or 1963 at a rate of one pack of cigarettes a day until cutting down to one-quarter of a pack of cigarettes a day at some unspecified time. Mr. Hutton complained of wheezing, a cough, shortness of breath, chest pain, two-pillow orthopnea, and ankle edema. Physical examination was normal. Based on the x-ray, Dr. Porterfield diagnosed coal workers' pneumoconiosis and emphysema. He attributed the emphysema to cigarette smoking. In his opinion, Mr. Hutton is totally disabled based on the blood gas study. Dr. Porterfield attributed that disability 50% to coal dust exposure and 50% to smoking.

The employer submitted the report of Robert J. Crisalli, M.D., dated October 14, 2002. DX 16. Dr. Crisalli noted complaints of shortness of breath ever since the claimant's myocardial infarction seven to eight years earlier, an occasional cough, sputum production, chest pain, and two-pillow orthopnea. Dr. Crisalli noted Mr. Hutton had worked fifteen years in the coal mines, lastly laying rack and rock dusting, both of which he considered heavy manual labor. He also considered a smoking history of one-third of a pack of cigarettes a day for thirty years but now smoking only one or two cigarettes a day.

Dr. Crisalli conducted an X-ray, a pulmonary function study and a blood gas study. The x-ray was read as negative (category 0/1). The blood gas study showed mild hypoxemia and the pulmonary function study evinced a mild obstructive ventilatory impairment and a moderate diffusion capacity defect. Physical examination revealed reduced breath sounds bilaterally. Dr. Crisalli also reviewed additional medical evidence, namely the reports of Drs. Ranavaya and Porterfield and the x-ray interpretations of Drs. Gaziano and Francke of the May 3, 1996 x-ray, as well as Dr. Patel's x-ray reading of the June 5, 2002 film.

Dr. Crisalli found that the Claimant does not have coal workers' pneumoconiosis. He diagnosed chronic obstructive pulmonary disease; hypertension; coronary artery disease with a past myocardial infarction and cardiac stents; sleep apnea; and hypothyroidism. In his opinion, the miner has a respiratory impairment sufficient to prevent him from performing heavy manual

labor, including some coal mining jobs. Dr. Crisalli felt it likely that Mr. Hutton's pulmonary function would improve to the point that he could perform heavy manual labor if he took bronchodilators. He opined that any impairment is unrelated to coal mine employment or pneumoconiosis. Rather, he attributed it to sleep apnea and chronic obstructive pulmonary disease due to smoking. He stated that his opinion regarding disability would remain the same even if Mr. Hutton were found to have pneumoconiosis.

Dr. Crisalli was deposed on April 12, 2004. EX 8. He provided his credentials and reviewed the results of his examination. He noted that other physicians recorded smoking histories of about twenty pack-years. Dr. Crisalli testified that the pulmonary function study he administered showed a mild airflow obstruction but no restrictive defect. He stated that significant improvement on bronchodilators indicates bronchial hyperactivity that could be due to asthma or smoking. He also found a moderate diffusion defect. Dr. Crisalli again espoused that the miner's mild to moderate impairment was primarily to chronic obstructive pulmonary disease caused by smoking and also possibly due to sleep apnea. He ruled out coal dust exposure as a cause because the obstruction is mild and reversible, and the Claimant's exhibited air trapping is consistent with emphysema. Furthermore, he explained that the ratio between the diffusion capacity and the alveolar volume is consistent with emphysema. While acknowledging that coal dust exposure can cause COPD, he added that it would not cause a significant degree of air trapping and would not be reversible. Dr. Crisalli attributed Claimant's hypoxemia to sleep apnea and being overweight more so than the COPD. He again opined that Mr. Hutton suffers no pulmonary impairment due to coal dust exposure. Dr. Crisalli is board certified in internal medicine and pulmonary disease.

Employer engaged George L. Zaldivar, M.D., to examine Mr. Hutton on January 8, 2003. DX 17. Dr. Zaldivar considered a medical history of surgery to remove a lung tumor in 1981, two heart attacks, and coronary bypass surgery. He noted symptoms of shortness of breath since 1971, barely being able to walk without losing his breath, and chest tightness. Dr. Zaldivar considered a history of smoking three-quarters of a pack of cigarettes a day beginning at the age of nineteen but now smoking cigars with great variability, and sixteen years of coal mine employment, lastly as a shuttle car operator and face man. The physical examination produced no significant findings.

Dr. Zaldivar reviewed the results of an x-ray, a pulmonary function study and a blood gas study. The x-ray was considered negative for pneumoconiosis, and the pulmonary function study showed a mild irreversible obstruction, normal lung volumes, and a moderate diffusion impairment. Dr. Zaldivar further reviewed three readings of the 1996 x-ray, two readings of the June 2002 x-ray, one reading of the October 2002 x-ray, and the reports of Drs. Ranavaya, Porterfield, and Crisalli.

Dr. Zaldivar diagnosed cardiac disease; no radiographic evidence of pneumoconiosis; mild resting hypoxemia; and a mild irreversible obstruction, normal lung volumes, and a moderate diffusion impairment. In his opinion, the miner's pulmonary impairment is due to pulmonary fibrosis with a decrease in diffusion capacity, not coal mine employment. He felt that the miner's mild obstruction is due to his smoking habit and is too mild to cause any impairment. From a pulmonary standpoint, Dr. Zaldivar felt it was unknown whether the Claimant can

perform his usual coal mine employment because he could not perform an after-exercise blood gas study. Dr. Zaldivar opined that Mr. Hutton possibly could not perform his coal mine employment based on his low diffusion capacity, which predicts a worsening of hypoxemia during exercise. Even if the miner were found to have pneumoconiosis, Dr. Zaldivar stated that his opinion would not change. He further stated that the pulmonary fibrosis is of an undetermined etiology but is not the manifestation of coal workers' pneumoconiosis. He further averred that the Claimant's cardiac disease might be disabling.

Dr. Zaldivar was deposed on April 12, 2004. EX 7. He stated that he is board certified in internal medicine, pulmonary disease, sleep disorder medicine, and critical care medicine. Dr. Zaldivar pointed out that none of the miner's medications were for pulmonary disorders. He added that the beta blocker Mr. Hutton takes could cause bronchospasm. He testified that he was given a history of smoking one-half pack of cigarettes a day from the age of eighteen until 1981 when he slowed down. Dr. Zaldivar acknowledged that all of the miner's coal mining jobs required heavy manual labor. He attributed the miner's moderately low diffusion capacity to smoking, explaining that the smoking led to inflammation of the airways and an increase of carbon monoxide in the blood. Dr. Zaldivar believed that in this case smoking has caused emphysema, interstitial fibrosis, and bronchiolitis. He stated that the diffusion capacity defect is also due to cardiac dysfunction but not coal workers' pneumoconiosis. Dr. Zaldivar testified that the pulmonary function study showed a mild obstruction, which he attributed to smoking. He described smoking as a powerful inducer of airway obstruction by damaging the airways (known as emphysema) and the production of mucous, which slows the air flow. Dr. Zaldivar acknowledged that coal dust exposure can cause an obstructive impairment. When asked to explain the variability in his pulmonary function study results compared to Dr. Crisalli's, he opined that the reversibility shown in Dr. Crisalli's study was probably due to asthma, which affects the tonicity of the airways, and not coal dust exposure. In his opinion, the miner has a significant cardiac disease that impairs him, but from a pulmonary standpoint he can perform heavy manual labor.

CONCLUSIONS OF LAW

Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202–718.205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Subsequent Claim

The Claimant's last work as a coal miner was within the State of West Virginia, which is located within the jurisdiction of the Fourth Federal Circuit. The Benefits Review Board applies

the law as it is interpreted by the applicable Circuit. *Shupe v. Director, OWCP*, 12 BLR 1-200 (1989).

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. *See* 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim, which is denied on the basis of the prior denial unless the claimant demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d) (2001). Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993, 997–998 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

The Court of Appeals for the Fourth Circuit, which has jurisdiction over this claim, has followed the *Sharondale* approach. *Lisa Lee Mines v. Director, OWCP*, 57 F.3d 402 (1995), *aff'd* 86 F.3d 1358 (4th Cir. 1996) (*en banc*). I interpret the *Sharondale* approach to mean that the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Circuit 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

The amended Regulations make clear that the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. 20 C.F.R. § 725.309(d)(2). In the denial of the miner's prior claim, it was found that he failed to establish either the existence of pneumoconiosis or total respiratory disability. Therefore, my inquiry begins with an investigation of whether the newly submitted evidence establishes either the existence of pneumoconiosis or total disability. Because I find that Claimant has established the latter, as is discussed below, I will begin the analysis with that issue.

Total Disability

The Claimant must show that his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding that the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony. Under this subsection, the ALJ must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, then the ALJ must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on recon. en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable to this claim because there is no evidence that the Claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or a deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. A claimant may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies showing an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the bloodstream. 20 C.F.R. § 718.204(b)(2)(ii). More weight may be accorded to the results of a recent blood gas study over one conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993).

In the instant matter, none of the pre-bronchodilator or post-bronchodilator tests produced qualifying results. Accordingly, I find that Claimant has not established total disability pursuant to § 718.204(b)(2)(i).

Of the three blood gas studies of record, all of which were performed at rest, the June 4, 2002 study produced qualifying values and was found technically acceptable by Dr. Gaziano, who is Board-certified in internal medicine and chest disease. However, the two more recent studies, administered October 14, 2002 and January 8, 2003, did not yield qualifying values. More weight may be accorded to the results of recent blood gas studies over studies conducted earlier. *Schretroma v. Director, OWCP*, 18 BLR 1-17 (1993). Accordingly, despite the earlier qualifying study, I find that the blood gas study evidence fails to establish total disability by a preponderance of the evidence, pursuant to § 718.204(b)(2)(ii).

Total disability may also be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable and gainful work. 20 C.F.R.

§ 718.204(b). Under this subsection, I must examine all the evidence of record "relevant to the question of total disability due to pneumoconiosis … with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201, 1-204 (1986). I must compare the exertional requirements of the Claimant's usual coal mine employment with a physician's assessment of the Claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once the miner has demonstrated that he is unable to perform his usual coal mine work, he has made a prima facie case of total disability; the burden of going forward with evidence to prove that the Claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined at § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

Drs. Porterfield and Crisalli found Mr. Hutton to be totally disabled, while Dr. Zaldivar opined that the Claimant is capable of performing coal mine employment from a pulmonary perspective. I credit Dr. Porterfield's opinion on this issue because it is supported by the qualifying blood gas study he administered that was validated by a reviewing physician. However, his physical examination of the miner revealed nothing abnormal, and he did not point to any of the miner's presenting symptoms as specifically supporting a finding of total disability. Accordingly, Dr. Porterfield's opinion, although credited, is not entitled to great weight.

Dr. Crisalli's opinion is supported by his thorough examination of the Claimant. It is well documented and reasoned. He was aware of the exertional requirements of Mr. Hutton's jobs as a rock duster and track layer. His physical examination revealed diminished breath sounds bilaterally, and he had the results of Dr. Porterfield's examination to also consider. Those results included the qualifying blood gas study. For these reasons, and because of Dr. Crisalli's impressive qualifications, I place great weight on his opinion.

Dr. Zaldivar's opinion is more equivocal than either Dr. Porterfield's or Dr. Crisalli's. He initially concluded that Claimant's mild obstruction was too mild to cause any impairment. From a pulmonary standpoint, Dr. Zaldivar felt it was unknown whether the Claimant could perform his usual coal mine employment because he could not perform an after-exercise blood gas study. Dr. Zaldivar opined that Mr. Hutton possibly could not perform his coal mine employment based on his low diffusion capacity which predicts a worsening of hypoxemia during exercise. At his deposition, Dr. Zaldivar testified that Mr. Hutton has only a mild impairment and has plenty of pulmonary function to do whatever he needs or wants to do. This change in, or strengthening of, opinion was due to a comparison of the pulmonary function study he administered with those conducted by Dr. Porterfield and Dr. Crisalli. I consider Dr. Zaldivar's opinion on this issue confusing and too indefinite to merit much weight. *Justice v. Island Creek Coal Co.*, 11 BLR 1-91 (1988). Therefore, I discount it.

Based on this reasoning, I credit the opinions of Drs. Porterfield and Crisalli over Dr. Zaldivar's and find that the evidence tends to establish total disability pursuant to § 718.204(b)(2)(iv).

After consideration of all the evidence under § 718.204(b)(2), like and unlike, I find the medical opinion testimony of Drs. Porterfield and Crisalli, as supported by the June 2002 blood

gas study, to be the most probative. I rely on the medical opinions because they are not based on the result of a sole test but are the culmination of a physical examination of the Claimant, an understanding of the exertional requirements of his coal mine employment, and years of experience in the field of pulmonary medicine. Accordingly, I find that Claimant has established, by a preponderance of the evidence, that he is totally disabled. Thus, he has also demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d) (2001). As a result, all the evidence must be weighed to determine whether Claimant is entitled to benefits under the Act.

Existence of Pneumoconiosis

The Regulations define pneumoconiosis broadly, as "a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment." 20 C.F.R. § 718.201. The Regulations' definition includes not only medical, or "clinical," pneumoconiosis but also statutory, or "legal," pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

> Those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silico-tuberculosis, arising out of coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes "any chronic lung disease or impairment and its sequelae" if that disease or impairment arises from coal-mine employment. *Id.* A claimant's condition "arises out of coal mine employment" if it is a "chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." *Id.* Finally, the Regulations reiterate that pneumoconiosis is "a latent and progressive disease" that might only become detectable after a miner's exposure to coal dust ceases. *Id.*

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987). However, this rule is not mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320.

The Regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)–(4). As there is no autopsy or biopsy evidence and Claimant is not eligible for the

presumptions,[2] only chest x-rays and medical opinions can establish the existence of pneumoconiosis in his claim. In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 4th Cir. 2000).

The May 3, 1996 x-ray was found positive by Dr. Ranavaya, with a reading of category 1/0 pneumoconiosis. Dr. Ranavaya is neither a radiologist nor a B-reader. Dr. Gaziano, a B-reader, reread the film as negative. Dr. Francke, who is both a B-reader and a board-certified radiologist, felt that the x-ray was negative for pneumoconiosis. All three physicians found the film to be of excellent quality. I defer to the superior credentials of Dr. Gaziano, and especially Dr. Francke, and thus consider this x-ray negative for pneumoconiosis.

The June 5, 2002 x-ray was found to be a quality two film by Dr. Binns, a board-certified radiologist who is also a B-reader. Dr. Patel found the x-ray positive for pneumoconiosis with a reading of category 1/0. He also found the film to be quality two. Dr. Wiot reread the x-ray as negative for pneumoconiosis but showing emphysema. He felt the quality of the film was one. Both Dr. Patel and Dr. Wiot are dually certified readers. Thus, I cannot rely on physician credentials to place more weight on one reading than the other. Although Dr. Wiot felt the film quality was better than Dr. Patel did, Dr. Patel's interpretation of the quality matches Dr. Binn's, and and both quality one and quality two films are considered sufficient to reliably interpret. Consequently, I do not find that the difference in quality readings affects my decision. Because the interpretations are directly contradictory, I consider this x-ray to be in equipoise. Therefore, I do not find it positive for the existence of pneumoconiosis.

The x-ray taken October 14, 2002 was found negative by Dr. Meyer, a dually certified reader. It was not reread. Consequently, I consider it negative. Similarly, Dr. Spitz, a dually certified reader, read the January 8, 2003 x-ray as negative. The Claimant did not have it reread. Thus, I consider this x-ray to be negative.

The final x-ray of evidence was taken March 5, 2004. Dr. Miller, a B-reader, found it positive with a reading of category 1/1. He felt it was a quality two film. Dr. Pathak, a board-certified radiologist and B-reader, found it positive with a reading of category 1/2. He felt it was a quality three film that also showed emphysema. Dr. Wiot reread this x-ray as negative, believing that the film was quality two. While Dr. Pathak is a B-reader, he considered the film to be of such poor quality that I place little weight on his reading. *Gober v. Reading Anthracite Co.*, 12 BLR 1-67 (1988). Thus, I am left with the contrary readings of Drs. Miller and Wiot, who both found the film to be quality two. However, because of Dr. Wiot's superior credentials, I place greater weight on his reading. *Scheckler v. Clinchfield Coal Co.*, 7 BLR 1-128 (1984). Therefore, I also consider this x-ray negative.

In summary, there are seven readings by B-readers who are also board-certified radiologists. Of these readings, two are positive and five are negative. Based on the above reasoning and because more of the best qualified readers found the x-ray negative, I conclude

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[2] Claimant is ineligible for the § 718.304 presumption because he has not been diagnosed with complicated pneumoconiosis. Claimant cannot qualify for the § 718.305 presumption because he did not file this claim before January 1, 1982. Claimant is ineligible for the § 718.306 presumption because he is still living.

that Claimant has failed to establish, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Additionally, a determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a). Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 BLR 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report to be not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 BLR 1-1130 (1984). A medical opinion is not sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 BLR 1-368 (1983).

Drs. Ranavaya and Porterfield diagnosed pneumoconiosis, while Drs. Crisalli and Zaldivar did not. In this case, I place less weight on the opinions of Dr. Ranavaya and Dr. Porterfield because they indicated that their findings were based on the miner's coal mine employment history and x-ray alone. In *Cornett v. Benham Coal Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute "sound" medical judgment under Section 718.202(a)(4). *Id.* at 576. The Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 BLR 1-105, 1-110 (1993) (*citing Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-113(1989), and *Taylor v. Brown Badgett, Inc.*, 8 BLR 1-405 (1985)). In *Taylor*, the Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 BLR at 1-407. The Board stated that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray... and not a reasoned medical opinion." *Id.* As Dr. Ranavaya and Dr. Porterfield fail to state any other basis for their diagnoses of pneumoconiosis beyond the x-ray and exposure history, I find their reports neither well-reasoned nor well-documented. Consequently, I do not place probative weight on their conclusions.

Dr. Zaldivar had the opportunity to review additional documentary evidence of record, thus providing him with a broader base from which to draw his conclusions. Furthermore, Dr. Zaldivar's opinion is consistent with the overall weight of the radiographic evidence, and his own x-ray was re-read by Dr. Spitz as negative for pneumoconiosis. Finally, Dr. Zaldivar possesses credentials worthy of great deference. *Id*. However, I find Dr. Zaldivar's reasoning unconvincing: the physician stated that Claimant has pulmonary fibrosis of unknown etiology, but stated unequivocally that the cause is *not* coal-mine dust exposure. *Id*. Dr. Zaldivar failed to explain how he eliminated occupational coal-dust exposure as a possible cause, when he was able to make no other positive statement about the etiology of the problem. Because Dr. Zaldivar's finding of no pneumoconiosis was not sufficiently reasoned on this point, I give it little weight.

Dr. Crisalli, who also relied in part on a review of the other evidence of record, provided an opinion that is well documented and reasoned. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). The x-ray on which he relied is consistent with the overall x-ray evidence. He possesses superior credentials in the field of pulmonary medicine. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). Consequently, I place great weight on his opinion in this matter.

Weighing all the evidence together, I find that the negative x-ray interpretations, when combined with the medical opinion of Dr. Crisalli, fail to establish the existence of pneumoconiosis.

Cause of Pneumoconiosis

Had it been determined that the miner suffers from pneumoconiosis, it would also have to be determined whether the miner's pneumoconiosis arose, at least in part, out of his coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

I find that Claimant, with fifteen years of coal mine employment, would be entitled to the rebuttable presumption at § 718.203. However, because he has not established the existence of pneumoconiosis, this issue is moot.

Total Disability Causation

Claimant must establish by a preponderance of the evidence that his total disability is due to pneumoconiosis. *Baumgartner v. Director, OWCP*, 9 BLR 1-65, 1-66 (1986); *Gee v. Moore & Sons*, 9 BLR 1-4, 1-6 (1986) (*en banc*). The amended Regulations require that the pneumoconiosis be a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Section 718.204(c)(1) (2001) sets forth that pneumoconiosis is a substantially contributing cause of disability if it either (1) has a material adverse effect on the miner's respiratory condition or (2) materially worsens a totally disabling respiratory impairment caused by a disease unrelated to coal mine employment.

Dr. Ranavaya did not find Mr. Hutton to be totally disabled but did attribute the mild disability he found to pneumoconiosis "to a major extent." Dr. Porterfield apportioned Mr. Hutton's disability one-half to smoking and one-half to coal dust exposure. Dr. Crisalli opined that the miner's disability is unrelated to pneumoconiosis and coal mine employment. He felt it was due to chronic obstructive pulmonary disease caused by smoking and sleep apnea. Dr. Zaldivar felt that the Claimant was disabled due to pulmonary fibrosis unrelated to coal mine employment, smoking, and coronary artery disease.

Dr. Ranavaya's opinion of mild disability is supported by the results of the pulmonary function study and blood gas study he administered. His opinion regarding the causation of that mild impairment is reasonable given Mr. Hutton's coal mine employment history. However, he failed to discuss how the Claimant's extensive smoking history, clinical presentation, and symptoms supported his conclusion. Dr. Porterfield's opinion is well documented. *Perry v.*

Director, OWCP, 9 BLR 1-1 (1986). It is also well reasoned based on Mr. Hutton's smoking and coal mine employment histories. However, the flaw in both Dr. Porterfield's opinion and Dr. Ranavaya's opinion is that I have found that the evidence does not support a finding of pneumoconiosis. Therefore, despite the acceptable logic of their conclusions, I must discount them because they are contrary to my underlying finding of no pneumoconiosis.

Dr. Crisalli and Dr. Zaldivar are both Board-certified in internal medicine and pulmonary disease. Dr. Zaldivar holds further board certificates in sleep disorder medicine and critical care medicine. These credentials lend great credence to their determinations. They also reviewed all the medical evidence of record, thus providing them with a broad base of data from which to draw their conclusions. Both Dr. Crisalli and Dr. Zaldivar explained how they were able to rule out coal dust exposure as a cause of Mr. Hutton's disability. The 1996, October 2002, and January 2003 pulmonary function tests all demonstrated reversibility after the administration of bronchodilators. They testified that this kind of condition is caused by bronchial hyperactivity such as asthma or a smoke-induced condition, not pneumoconiosis, which results in a fixed impairment. Dr. Crisalli testified that the demonstrated air trapping and the ratio between the miner's diffusion capacity and alveolar volume are consistent with emphysema. Several of the best x-ray readers found emphysema radiograpically, thereby adding verisimilitude to Dr. Crisalli's opinion. He also stated that coal dust exposure can cause COPD but without a significant degree of air trapping and no reversibility. Furthermore, Dr. Crisalli explained that the hypoxemia seen on the blood gas studies was caused by sleep apnea and being overweight. Mr. Hutton provided a history of sleep apnea, and there is no question that he is overweight. Because of his credentials and cogent reasoning, I place great weight on Dr. Crisalli's opinion.

Dr. Zaldivar is the only physician who opined that Claimant has interstitial fibrosis. That finding was not made by any of the radiologists. Consequently, his opinion that Mr. Hutton's mild impairment is due to pulmonary fibrosis with a decrease in diffusion capacity lacks credibility. I find that the evidence does not support his diagnosis of interstitial fibrosis. However, at his deposition, Dr. Zaldivar's testimony buttressed Dr. Crisalli's. He attributed Claimant's moderately low diffusion capacity to smoking. He explained that smoking is a powerful inducer of airway obstruction because it damages the airways with emphysema and causes mucous production, which slows air flow. He also relied on the reversibility of Mr. Hutton's pulmonary disorder to rule out coal dust exposure as a cause of it. Dr. Zaldivar was also the only doctor to place some of the blame for Claimant's disability on his cardiac dysfunction, and this is certainly reasonable based on Mr. Hutton's history of two myocardial infarctions and coronary bypass surgery. Therefore, although I find Dr. Zaldivar's opinion somewhat troubling, I place weight on it to the extent that it supports Dr. Crisalli's well-reasoned opinion.

Based on the foregoing analysis, I find that Claimant has failed to establish, by a preponderance of the evidence, that pneumoconiosis is a substantially contributing cause of his disability.

Conclusion

As Claimant has failed to establish all elements of entitlement, I conclude that he has not established entitlement to benefits under the Act.

Attorney's Fees

The award of attorney's fees under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation services rendered to him in pursuit of the claim.

ORDER

It is ordered that the claim of EMMIT H. HUTTON for benefits under the Black Lung Benefits Act is hereby DENIED.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days of the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.